FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0005405

Facility Name: HILLTOP CONVALESCENT CENTER

Address: 910 W. POLK (Number) CHARLESTON (City) 61920 (Zip Code)

County: COLES

Telephone Number: 217-345-7006 **Fax #** 217-345-6017

IDPA ID Number: 370776670001

Date of Initial License for Current Owners: 07/01/1958

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: JERRY W. JENNINGS **Telephone Number:** 217-787-8530

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 08/01/03 to 07/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) JERRY W. JENNINGS

(Title) CONTROLLER

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/03 Ending: 07/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	36	Skilled (SNF)	36	13,176	1
2		Skilled Pediatric (SNF/PED)			2
3	72	Intermediate (ICF)	72	26,352	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	108	TOTALS	108	39,528	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	123		3,641	3,764	8
9	SNF/PED					9
10	ICF	11,331	7,259		18,590	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,454	7,259	3,641	22,354	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 56.55%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 7/1/58

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 25 and days of care provided 3,641

Medicare Intermediary ADMINASTAR FEDERAL OF KENTUCKY

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: 7/31/04 Fiscal Year: 7/31/04

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/03 Ending: 07/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	81,562	9,464	6,444	97,470		97,470		97,470			1
2	Food Purchase		86,791		86,791		86,791	(1,623)	85,168			2
3	Housekeeping	30,432	7,597		38,029		38,029		38,029			3
4	Laundry	18,474	8,502		26,976		26,976		26,976			4
5	Heat and Other Utilities			60,897	60,897		60,897		60,897			5
6	Maintenance	29,354	27,551	33,815	90,720		90,720	696	91,416			6
7	Other (specify):* UTILITY WORKERS	1,457			1,457		1,457		1,457			7
8	**TOTAL General Services**	161,279	139,905	101,156	402,340		402,340	(927)	401,413			8
	B. Health Care and Programs											
9	Medical Director			11,800	11,800		11,800		11,800			9
10	Nursing and Medical Records	739,445	142,458	60,372	942,275	(104,507)	837,768	4,765	842,533			10
10a	Therapy	18,983	2,368	208,470	229,821	(208,470)	21,351		21,351			10a
11	Activities	29,889	2,260		32,149		32,149		32,149			11
12	Social Services	28,652		3,522	32,174		32,174		32,174			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	816,969	147,086	284,164	1,248,219	(312,977)	935,242	4,765	940,007			16
	C. General Administration											
17	Administrative	58,076		13,389	71,465	1,516	72,981	35,019	108,000			17
18	Directors Fees											18
19	Professional Services			126,341	126,341		126,341	(117,455)	8,886			19
20	Dues, Fees, Subscriptions & Promotions			13,922	13,922		13,922	(5,345)	8,577			20
21	Clerical & General Office Expenses	40,005	10,731	7,104	57,840		57,840	24,219	82,059			21
22	Employee Benefits & Payroll Taxes			159,208	159,208		159,208	14,041	173,249			22
23	Inservice Training & Education			917	917		917	1,099	2,016			23
24	Travel and Seminar			4,872	4,872	(4,004)	868	475	1,343			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			85,263	85,263		85,263		85,263			26
27	Other (specify):*			20,940	20,940		20,940	(20,940)				27
28	**TOTAL General Administration**	98,081	10,731	431,956	540,768	(2,488)	538,280	(68,887)	469,393			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,076,329	297,722	817,276	2,191,327	(315,465)	1,875,862	(65,049)	1,810,813			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number HILLTOP CONVALESCENT CENTER #0005405 Report Period Beginning: 08/01/03 Ending: 07/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			19,828	19,828		19,828	3,398	23,226			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			31,867	31,867		31,867		31,867			33
34	Rent-Facility & Grounds							4,311	4,311			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			51,695	51,695		51,695	7,709	59,404			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					315,465	315,465		315,465			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			59,292	59,292		59,292		59,292			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			59,292	59,292	315,465	374,757		374,757			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,076,329	297,722	928,263	2,302,314		2,302,314	(57,340)	2,244,974			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/03 Ending: 07/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(715)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,688	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(446)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,629)	27		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(500)	20		17
18	Fines and Penalties	(4,143)	27		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(8,872)	27		24
25	Fund Raising, Advertising and Promotional	(4,884)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(4,296)	27		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule VENDING	(908)	2		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (26,705)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(30,635)	VAR	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (30,635)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (57,340)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39	THERAPY	X		208,470	10A	39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology	X		6,075	10	42
43	Prescription Drugs	X		85,176	10	43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule OXYGEN	X		9,518	10	45
46	Other-Attach Schedule X-RAY, IV	X		6,226	10	46
47	**TOTAL (C): (sum of lines 38-46)**			$ 315,465		47

HILLTOP CONVALESCENT CENTER

ID# 0005405

Report Period Beginning: 08/01/03

Ending: 07/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/03 Ending: 07/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(715)	0	0	0	0	0	0	0	0	0	0	(715)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(715)	0	0	0	0	0	0	0	0	0	0	(715)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	214	0	0	0	0	0	0	0	0	0	214	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(117,381)	0	0	0	0	0	0	0	0	0	(117,381)	19
20	Fees, Subscriptions & Promotions	(5,384)	0	0	0	0	0	0	0	0	0	0	(5,384)	20
21	Clerical & General Office Expenses	(446)	0	0	0	0	0	0	0	0	0	0	(446)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	(214)	0	0	0	0	0	0	0	0	0	(214)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(20,940)	0	0	0	0	0	0	0	0	0	0	(20,940)	27
28	**TOTAL General Administration**	(26,770)	(117,381)	0	0	0	0	0	0	0	0	0	(144,151)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(27,485)	(117,381)	0	0	0	0	0	0	0	0	0	(144,866)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number HILLTOP CONVALESCENT CENTER **#** 0005405 **Report Period Beginning:** 08/01/03 **Ending:** 07/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	1,688	0	0	0	0	0	0	0	0	0	0	1,688	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	1,688	0	0	0	0	0	0	0	0	0	0	1,688	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(25,797)	(117,381)	0	0	0	0	0	0	0	0	0	(143,178)	45

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/03 Ending: 07/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
H. RAYMOND KLEIN	78.18	JACKSONVILLE CONVALESCENT CENTER	JACKSONVILLE	Nursing Home Mngr	SPRINGFIELD	MANAGEMENT
DANA KLEIN KAVY	4.24	MEADOW MANOR	TAYLORVILLE			
PHILIP KLEIN	4.24	MENARD CONVALESCENT CENTER	PETERSBURG			
LISA KLEIN GILDAR	4.24	SUNRISE MANOR OF VIRDEN	VIRDEN			
DAVID & RAQUEL KLEIN	4.55					
JERRY & PAULA JENNINGS	4.55					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	MANAGEMENT FEE	$ 126,043	NURSING HOME MANAGERS	39.39%	$	$ (126,043)	1
2	V	VAR	SEE ATTACHED SCHEDULES		NURSING HOME MANAGERS	39.39%	86,746	86,746	2
3	V	19	ACCOUNTING		NURSING HOME MANAGERS DIRECT ALLOCATION		8,662	8,662	3
4	V	24	TRAVEL	214	TO TRANSFER 31% OF HOME OFFICE TRAVEL			(214)	4
5	V	17	ADMINISTRATIVE		TO ADMINISTRATIVE PER DESK REVIEW		214	214	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 126,257			$ 95,622	$ * (30,635)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/03 Ending: 07/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	JERRY JENNINGS	CONTROLLER	MANAGEMENT	4.55					$ 15,160	17-7	1
2	H. RAYMOND KLEIN	OWNER	MANAGEMENT	78.18					1,702	17-7	2
3											3
4											4
5		H. RAYMOND KLEIN AND JERRY JENNINGS WERE PAID BY NURSING HOME									5
6		MANAGERS, INC., A RELATED ORGANIZATION. TOTAL COMPENSATION									6
7		OF $10,010 FOR H. RAYMOND KLEIN WAS ALLOCATED AMONG THE FIVE									7
8		RELATED NURSING HOMES BASED UPON 10 HOURS PER WEEK. TOTAL									8
9		COMPENSTATION OF $78,198 FOR JERRY JENNINGS WAS ALLOCATED AMONG									9
10		THE FIVE RELATED NURSING HOMES BASED UPON 35 HOURS PER WEEK.									10
11											11
12											12
13								TOTAL	$ 16,862		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/03 Ending: 07/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: NURSING HOME MANAGERS
Street Address: 2653 W. LAWRENCE, SUITE B
City / State / Zip Code: SPRINGFIELD, IL 62704
Phone Number: (217) 787-8530
Fax Number: (217) 787-9840

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		SEE ATTACHED SCHEDULES				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/03 Ending: 07/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/03 Ending: 07/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2003 report.	$	33,720	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	15,563	2
3. Under or (over) accrual (line 2 minus line 1).	$	(18,157)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	50,024	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	31,867	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	34,533	8
	2000	35,172	9
	2001	29,241	10
	2002	31,126	11
	2003	31,594	12

LINE 2 2ND INSTALLMENT 2002 $15,563 LINE 4 BOTH INSTALLMENTS 2003 $31,594

7/12 $31,594 18,430

TOTAL $50,024

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME HILLTOP CONVALESCENT CENTER COUNTY COLES

FACILITY IDPH LICENSE NUMBER 0005405

CONTACT PERSON REGARDING THIS REPORT JERRY W. JENNINGS

TELEPHONE 217-787-8530 FAX #: 217-787-9840

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	02-1-00706-000	HILLTOP NURSING HOME	$ 31,593.86	$ 31,593.86
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 31,593.86	$ 31,593.86

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/03 Ending: 07/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,709 B. General Construction Type: Exterior MASONRY Frame WOOD & STEEL Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		1966	$ 5,295	1
2					2
3	TOTALS			$ 5,295	3

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/03 Ending: 07/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	72		1966		$ 253,434	$	30	$	$	$ 253,434	4
5	36			1972	240,043		30			240,043	5
6											6
7											7
8											8
	Improvement Type**										
9	LANDSCAPING			1975	2,877		10			2,877	9
10	LANDSCAPING			1980	1,417		5			1,417	10
11	IMPROVEMENT			1979	17,131		15			17,131	11
12	IMPROVEMENT			1981	4,330		VARIOUS			4,330	12
13	IMPROVEMENT			1982	3,570		15			3,570	13
14	IMPROVEMENT			1983	3,583		15			3,583	14
15	IMPROVEMENT			1984	2,461		15			2,461	15
16	IMPROVEMENT			1985	14,201		15			14,201	16
17	AIR CONDITIONER			1986	1,620	84	10		(84)	1,620	17
18	CONDENSER			1986	3,068	160	15		(160)	3,068	18
19	ROOF			1986	19,843	1,032	15		(1,032)	19,843	19
20	CUBICAL TRACKS			1987	997	32	20	50	18	899	20
21	AIR CONDITIONER			1987	1,149	36	10		(36)	1,149	21
22	AIR CONDITIONER			1988	3,145	100	10		(100)	3,145	22
23	WATER HEATER			1988	982	31	15		(31)	982	23
24	WATER HEATER			1989	2,194	70	15	146	76	2,142	24
25	AIR CONDITIONER			1991	1,959	62	10		(62)	1,959	25
26	SIDEWALK			1991	3,120	99	20	156	57	2,132	26
27	WIRING			1992	1,384	44	20	69	25	887	27
28	AIR CONDITIONER			1992	1,474	47	10		(47)	1,474	28
29	DOOR ALARM, FURNACE, IMPROVEMENT			1993	6,664	212	15	444	232	5,107	29
30	LANDSCAPING			1993	2,824	188	10		(188)	2,824	30
31	BLACKTOP - PER 1991 AUDIT			1990	2,186		15	146	146	1,606	31
32	AIR CONDITIONER			1994	1,613	41	10	136	95	1,613	32
33	LIGHTING			1995	2,729	70	10	273	203	2,593	33
34	AIR CONDITIONER			1996	1,112	29	8	127	98	1,112	34
35	EXHAUST FAN, FLOORING, WATER HEATERS			1996	5,048	129	15	337	208	2,862	35
36	REMODELING - WALLS			1996	1,080	28	30	36	8	288	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/03 Ending: 07/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	WATER HEATER	1996	$ 1,611	$ 41	15	$ 107	$ 66	$ 823	37
38	REMODELING - WALLS	1997	10,714	275	30	357	82	2,589	38
39	AIR CONDITIONER	1999	3,185	82	10	319	237	1,780	39
40	ROOF	1999	68,332	1,752	20	3,417	1,665	17,652	40
41	FURNACE	2000	1,273	33	15	85	52	410	41
42	AIR CONDITIONER	2001	1,404	36	10	140	104	561	42
43	GAZEBO	2001	1,374	35	15	91	56	351	43
44	SMOKE DETECTORS	2001	1,648	42	15	110	68	293	44
45	FIRE DAMPERS	2002	1,451	37	15	97	60	242	45
46	FURNACE	2002	2,200	56	15	147	91	367	46
47	EXHAUST RENOVATIONS	2002	8,298	213	15	553	340	1,337	47
48	FIRE/RADIATION DAMPERS	2002	1,770	45	15	118	73	266	48
49	AIR CONDITIONER	2003	3,200	82	10	320	238	613	49
50	WATER HEATER	2004	4,320	106	15	288	182	288	50
51	FURNACE	2004	1,525	18	15	51	33	51	51
52	SIDEWALKS	2004	3,375	18	15	56	38	56	52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 722,918	$ 5,365		$ 8,176	$ 2,811	$ 628,031	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/03 Ending: 07/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 153,862	$ 9,733	$ 11,982	$ 2,249	VARIOUS	$ 100,259	71
72	Current Year Purchases	30,434	4,730	1,358	(3,372)	VARIOUS	1,358	72
73	Fully Depreciated Assets	159,092					159,092	73
74		(58,078)					(58,078)	74
75	TOTALS	$ 285,310	$ 14,463	$ 13,340	$ (1,123)		$ 202,631	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,013,523	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 19,828	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 21,516	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 1,688	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 830,662	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/03 Ending: 07/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$	2,229	$ 95,516	$	2,229	$ 95,516	1
2	Licensed Speech and Language Development Therapist		hrs		155	9,892		155	9,892	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		1,897	103,062		1,897	103,062	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				85,176		85,176	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): IV, Oxygen, Labs, X-Rays						21,819		21,819	13
14	TOTAL			$	4,280	$ 208,470	$ 106,995	4,280	$ 315,465	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number HILLTOP CONVALESCENT CENTER **#** 0005405 **Report Period Beginning:** 08/01/03 **Ending:** 07/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 07/31/04 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 223,065	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	367,771		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	18,513		6
7	Other Prepaid Expenses	17,468		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 626,817	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	5,295		13
14	Buildings, at Historical Cost	720,732		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	341,819		16
17	Accumulated Depreciation (book methods)	(893,643)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 174,203	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 801,020	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 139,348	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	20,712		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,496		31
32	Accrued Real Estate Taxes(Sch.IX-B)	50,024		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	4,296		35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 226,876	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 226,876	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 574,144	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 801,020	$	48

***(See instructions.)**

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/03 Ending: 07/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 465,782	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 465,782	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	281,612	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(173,250)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 108,362	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 574,144	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/03 Ending: 07/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,693,172	1
2	Discounts and Allowances for all Levels	(172,313)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,520,859	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	55,066	6
7	Oxygen	2,444	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 57,510	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	715	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	690	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,405	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,381	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,381	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING 908, ADMIT FEES 400, W/A 46	1,354	28
28a	BAD DEBT RECOVERY	1,417	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,771	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,583,926	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	402,340	31
32	Health Care	1,248,219	32
33	General Administration	540,768	33
	B. Capital Expense		
34	Ownership	51,695	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	59,292	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,302,314	40
41	**Income before Income Taxes (line 30 minus line 40)****	281,612	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 281,612	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/03 Ending: 07/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,000	2,080	$ 51,976	$ 24.99	1
2	Assistant Director of Nursing	1,120	1,120	25,800	23.04	2
3	Registered Nurses	6,627	6,917	130,746	18.90	3
4	Licensed Practical Nurses	10,997	11,184	161,964	14.48	4
5	Nurse Aides & Orderlies	39,534	40,652	368,959	9.08	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,722	1,760	18,983	10.79	8
9	Activity Director	2,084	2,205	19,428	8.81	9
10	Activity Assistants	1,650	1,650	10,461	6.34	10
11	Social Service Workers	3,010	3,118	28,652	9.19	11
12	Dietician					12
13	Food Service Supervisor	2,194	2,233	26,854	12.03	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,297	8,467	54,708	6.46	15
16	Dishwashers					16
17	Maintenance Workers	4,001	4,001	29,354	7.34	17
18	Housekeepers	5,062	5,192	30,432	5.86	18
19	Laundry	2,643	2,735	18,474	6.75	19
20	Administrator	2,000	2,080	58,076	27.92	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,920	4,125	40,005	9.70	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Utility Workers	239	239	1,457	6.10	33
34	TOTAL (lines 1 - 33)	97,100	99,758	$ 1,076,329 *	$ 10.79	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	203	$ 6,444	1-3	35
36	Medical Director	120	11,800	9-3	36
37	Medical Records Consultant	16	559	10-3	37
38	Nurse Consultant	388	20,108	10-3	38
39	Pharmacist Consultant	96	2,350	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	61	3,522	12-3	45
46	Other(specify) Utilization Review	48	2,200	10-3	46
47	ADMINISTRATIVE CONSULTANT	404	13,389	17-3	47
48	MEDICARE CONSULTANT	192	22,838	10-3	48
49	TOTAL (lines 35 - 48)	1,527	$ 83,210		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	17	$ 716	10-3	50
51	Licensed Practical Nurses	268	11,031	10-3	51
52	Nurse Aides	22	570	10-3	52
53	TOTAL (lines 50 - 52)	307	$ 12,317		53

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/03 Ending: 07/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ARACELI HENSON	ADMINISTRATOR	0	$ 58,076
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 58,076

B. Administrative - Other

Description	Amount
ADMINISTRATIVE CONSULTANT	$ 13,389
TOTAL (agree to Schedule V, line 17, col. 3)	$ 13,389
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
NURSING HOME MANAGERS	MANAGEMENT	$ 126,043
CSC	CORP. REPRESENTATION	298
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 126,341

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 28,989
Unemployment Compensation Insurance	10,091
FICA Taxes	79,905
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE LIFE INSURANCE	2,882
EMPLOYEE CAFETERIA PLAN	35,484
EMPLOYEE VACCINES	563
EMPLOYEE PHYSICALS	125
HOLIDAY PARTIES	436
GIFT CERTIFICATES	733
NURSING HOME MANAGERS ALLOCATION	14,041
TOTAL (agree to Schedule V, line 22, col.8)	$ 173,249

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
EMPLOYEE VACCINES	22	$ 563
EMPLOYEE PHYSICALS	22	125
HOLIDAY PARTIES	22	436
GIFT CERTIFICATES	22	733
TOTAL		$ 1,857

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,080
Advertising: Employee Recruitment	4,912
Health Care Worker Background Check	1,233
(Indicate # of checks performed 92)	
PUBLIC RELATIONS	4,884
CHAMBER OF COMMERCE DUES	500
CLIA LAB FEE	150
FRANCHISE FEE	163
NURSING HOME MANAGERS ALLOCAT	39
LESS: NON ALLOWABLE DUES	(500)
Less: Public Relations Expense	(4,884)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,577

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
MISC MILEAGE REIMBURSEMENT	868
LESS 31% TRANS. TO ADMINISTRATIVI	(214)
NURSING HOME MANAGERS ALLOCAT	689
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,343

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/03 Ending: 07/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	PAINT	9/90	$ 1,925	3 YRS	$	$	$	$	$	$	$	$	$
2	DECORATION	7/93	1,884	3 YRS									
3	PAINT & WALLCOVER	7/94	3,986	3 YRS									
4	PAINT & WALLPAPER	7/96	3,825	3 YRS									
5	PAINT & WALLPAPER	3/97	5,058	3 YRS									
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 16,678		$	$	$	$	$	$	$	$	$

Facility Name & ID Number HILLTOP CONVALESCENT CENTER **#** 0005405 **Report Period Beginning:** 08/01/03 **Ending:** 07/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **15 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **12,847** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **59,292**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **YES** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **715**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

PAGE 3 & 4 - SCHEDULE V

LINE 27 - OTHER GENERAL ADMINISTRATION

FINES	$	4,143
BAD DEBT		8,872
SALES TAX		3,629
ILLINOIS RT TAX		4,296
TOTAL LINE 27 - COLUMN 3	$	20,940

DETAIL OF RECLASSIFICATIONS - COLUMN 5

RECLASS FROM:			LINE #
OXYGEN	$	(9,518)	10
MEDICARE DRUGS		(85,176)	10
MEDICARE LAB FEES		(6,075)	10
MEDICARE IV'S		(4,929)	10
MEDICARE X-RAYS		(1,297)	10
PHYSICAL THERAPY		(103,062)	10A
SPEECH THERAPY		(9,892)	10A
OCCUPATIONAL THERAPY		(95,516)	10A
RECLASS TO: ANCILLARY SERVICES	$	315,465	39
RECLASS TO:			
NURSE CONSULTANT MILEAGE	$	2,488	10
ADMINISTRATIVE CONSULTANT MILEAGE		1,516	17
RECLASS FROM: TRAVEL	$	(4,004)	24

PAGE 13 - SCHEDULE XI - SECTION E

RECONCILIATION OF DEPRECIATION	$ 21,516
NURSING HOME MANAGERS ALLOCATION	1,710
SCHEDULE V - LINE 30 - COLUMN 8	$ 23,226

PAGE 23 - SCHEDULE XX - QUESTION 12

SALARY COSTS ALLOCATED TO DEPARTMENTS WORKED BASED UPON TIME CARDS.

PAGE 19 - SCHEDULE XVII

RECONCILIATION OF INCOME

NET INCOME - LINE 43	$ 281,612
* MANAGEMENT FEE 7/31/03	(9,356)
* MANAGEMENT FEE 7/31/04	9,741
INTEREST INCOME PASSED DIRECTLY TO SHAREHOLDERS	(1,381)
TAXABLE INCOME	$ 280,616

* RELATED PARTY ACCOUNTS PAYABLE NOT ALLOWE FOR TAX PURPOSES INCLUDED HERE FOR CONSISTEN WITH PRIOR COST REPORTS AND TO CONFORM TO ACCRUAL ACCOUNTING METHODS.

ED
NCY

PAGE 6 SCHEDULE VII B LINE 2
NURSING HOME MANAGERS COSTS

CENTRAL OFFICE COST ALLOCATION
HILLTOP
2003

	AUG 03	SEPT	OCT	NOV	DEC	JAN 04	FEB	MARCH	APRIL	MAY	JUNE	JULY	2003 TOTAL	LINE
SALARIES-ADMIN	$2,641	$2,657	$2,703	$2,717	$2,967	$2,906	$2,888	$2,700	$2,630	$2,660	$2,720	$2,674	$32,864	17
SALARIES-CLERIC	1,767	1,778	1,808	1,818	1,985	2,011	1,998	1,868	1,820	1,841	1,882	1,850	22,425	21
SALARIES-ACTIV	0	0	0	0	0	0	0	0	0	0	0	0	0	11
SALARIES-NURSE	264	266	270	272	297	515	511	478	466	471	482	473	4,765	10
ACCOUNTING	(30)	(30)	(31)	(31)	(34)	12	12	11	11	11	11	11	(74)	19
WORK COMP INS	3	3	3	3	3	17	17	16	16	16	16	16	127	22
SUPPLIES	62	62	63	63	69	109	108	101	98	99	102	100	1,036	21
TELEPHONE	91	91	93	93	102	111	110	103	100	102	104	102	1,204	21
EMPL BENEFITS	790	795	809	813	888	853	847	792	772	780	798	785	9,723	22
PAYROLL TAXES	240	242	246	247	270	395	392	367	357	361	369	363	3,849	22
TRAVEL	62	63	64	64	70	56	55	52	50	51	52	51	689	24
IN SERVICE	61	62	63	63	69	119	118	110	107	108	111	109	1,099	23
MEDICAL CONSULT	0	0	0	0	0	0	0	0	0	0	0	0	0	
MACHINE RENTAL	18	18	19	19	20	55	55	51	50	50	51	51	457	6
OWNERS COMP	155	156	159	160	174	172	171	160	156	158	161	159	1,941	17
INS-PROP,LIAB,WC	28	28	28	28	31	30	30	28	27	28	28	28	342	26
DEPRECIATION	136	137	140	140	153	152	151	141	138	139	142	140	1,710	30
RENT	350	352	358	360	393	378	376	351	342	346	354	348	4,311	34
MAINTENANCE	34	34	35	35	38	9	9	9	9	9	9	9	239	6
FEES & PUBLICAT	0	0	0	0	0	6	6	6	5	5	6	5	39	20
ADVERTISING	0	0	0	0	0	0	0	0	0	0	0	0	0	20
	0	0	0	0	0	0	0	0	0	0	0	0	0	
TOTAL	$6,673	$6,713	$6,830	$6,866	$7,497	$7,905	$7,856	$7,343	$7,154	$7,236	$7,400	$7,274	$86,746	
FIXED ASSETS														
EQUIP - PRIOR	7,581	7,627	7,759	7,800	8,517	12,812	12,732	11,900	11,594	11,727	11,992	8,109	10,012	
EQUIP - CURR	3,664	3,686	3,750	3,770	4,116	0	0	0	0	0	0	2,294	1,773	
EQUIP - FULLY DEP	3,499	3,520	3,581	3,600	3,931	3,987	3,962	3,703	3,608	3,649	3,732	3,668	3,703	
BLDG - PRIOR	1,232	1,240	1,261	1,268	1,385	1,404	1,395	1,304	1,271	1,285	1,314	1,292	1,304	
BLDG - CURR	0	0	0	0	0	0	0	0	0	0	0	0	0	
BLDG - FULLY DEP	0	0	0	0	0	0	0	0	0	0	0	0	0	

NURSING HOME MANAGERS
COST ALLOCATION
AUGUST 2003

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	18.33%	26.84%	18.24%	14.94%	21.65%	100.00%
SALARIES-ADMIN	$0	$2,641	$3,868	$2,629	$2,152	$3,120	$14,410
SALARIES-CLERIC	0	1,767	2,588	1,759	1,440	2,087	9,641
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	264	387	263	215	312	1,442
ACCOUNTING	0	(30)	(44)	(30)	(24)	(35)	(163)
WORK COMP INS	0	3	4	3	2	3	14
SUPPLIES	0	62	90	61	50	73	336
TELEPHONE	0	91	133	90	74	107	496
EMPL BENEFITS	0	790	1,158	787	644	934	4,313
PAYROLL TAXES	0	240	352	239	196	284	1,311
TRAVEL	0	62	91	62	51	74	340
IN SERVICE	0	61	90	61	50	72	334
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	0	18	27	18	15	21	99
OWNERS COMP	0	155	227	155	127	183	847
INS-PROP,LIAB,WC	0	28	40	27	22	33	150
DEPRECIATION	0	136	200	136	111	161	744
RENT	0	350	513	349	285	414	1,911
MAINTENANCE	0	34	50	34	28	40	186
FEES & PUBLIC	0	0	0	0	0	0	0
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$0	$6,673	$9,773	$6,642	$5,439	$7,884	$36,411
FIXED ASSETS							
EQUIP - PRIOR	0	7,581	11,103	7,546	6,179	8,957	41,365
EQUIP - CURR	0	3,664	5,366	3,647	2,986	4,329	19,992
EQUIP - FULLY DEP	0	3,499	5,124	3,483	2,852	4,134	19,092
BLDG - PRIOR	0	1,232	1,805	1,227	1,005	1,456	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
SEPTEMBER 2003

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	18.44%	26.51%	17.63%	15.56%	21.87%	100.00%
SALARIES-ADMIN	$0	$2,657	$3,820	$2,540	$2,242	$3,152	$14,410
SALARIES-CLERIC	0	1,778	2,556	1,699	1,500	2,109	9,641
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	266	382	254	224	315	1,442
ACCOUNTING	0	(30)	(43)	(29)	(25)	(36)	(163)
WORK COMP INS	0	3	4	3	2	3	14
SUPPLIES	0	62	89	59	52	73	336
TELEPHONE	0	91	131	87	77	108	496
EMPL BENEFITS	0	795	1,143	760	671	943	4,313
PAYROLL TAXES	0	242	348	231	204	287	1,311
TRAVEL	0	63	90	60	53	74	340
IN SERVICE	0	62	89	59	52	73	334
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	0	18	26	17	15	22	99
OWNERS COMP	0	156	225	149	132	185	847
INS-PROP,LIAB,WC	0	28	40	26	23	33	150
DEPRECIATION	0	137	197	131	116	163	744
RENT	0	352	506	337	297	418	1,911
MAINTENANCE	0	34	49	33	29	41	186
FEES & PUBLIC	0	0	0	0	0	0	0
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$0	$6,713	$9,652	$6,418	$5,664	$7,964	$36,411
FIXED ASSETS							
EQUIP - PRIOR	0	7,627	10,965	7,291	6,435	9,047	41,365
EQUIP - CURR	0	3,686	5,300	3,524	3,110	4,373	19,992
EQUIP - FULLY DEP	0	3,520	5,061	3,365	2,970	4,176	19,092
BLDG - PRIOR	0	1,240	1,783	1,185	1,046	1,471	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
OCTOBER 2003

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	18.76%	26.41%	17.06%	15.05%	22.72%	100.00%
SALARIES-ADMIN	$0	$2,703	$3,806	$2,459	$2,169	$3,274	$14,410
SALARIES-CLERIC	0	1,808	2,546	1,645	1,451	2,190	9,641
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	270	381	246	217	328	1,442
ACCOUNTING	0	(31)	(43)	(28)	(25)	(37)	(163)
WORK COMP INS	0	3	4	2	2	3	14
SUPPLIES	0	63	89	57	51	76	336
TELEPHONE	0	93	131	85	75	113	496
EMPL BENEFITS	0	809	1,139	736	649	980	4,313
PAYROLL TAXES	0	246	346	224	197	298	1,311
TRAVEL	0	64	90	58	51	77	340
IN SERVICE	0	63	88	57	50	76	334
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	0	19	26	17	15	22	99
OWNERS COMP	0	159	224	145	127	192	847
INS-PROP,LIAB,WC	0	28	40	26	23	34	150
DEPRECIATION	0	140	197	127	112	169	744
RENT	0	358	505	326	288	434	1,911
MAINTENANCE	0	35	49	32	28	42	186
FEES & PUBLIC	0	0	0	0	0	0	0
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$0	$6,830	$9,618	$6,212	$5,480	$8,272	$36,411
FIXED ASSETS							
EQUIP - PRIOR	0	7,759	10,926	7,057	6,226	9,397	41,365
EQUIP - CURR	0	3,750	5,281	3,411	3,009	4,542	19,992
EQUIP - FULLY DEP	0	3,581	5,043	3,257	2,873	4,337	19,092
BLDG - PRIOR	0	1,261	1,776	1,147	1,012	1,528	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
NOVEMBER 2003

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	18.86%	26.11%	16.84%	16.01%	22.18%	100.00%
SALARIES-ADMIN	$0	$2,717	$3,763	$2,427	$2,307	$3,197	$14,410
SALARIES-CLERIC	0	1,818	2,517	1,623	1,544	2,139	9,641
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	272	376	243	231	320	1,442
ACCOUNTING	0	(31)	(43)	(27)	(26)	(36)	(163)
WORK COMP INS	0	3	4	2	2	3	14
SUPPLIES	0	63	88	57	54	74	336
TELEPHONE	0	93	129	83	79	110	496
EMPL BENEFITS	0	813	1,126	726	691	957	4,313
PAYROLL TAXES	0	247	342	221	210	291	1,311
TRAVEL	0	64	89	57	54	75	340
IN SERVICE	0	63	87	56	54	74	334
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	0	19	26	17	16	22	99
OWNERS COMP	0	160	221	143	136	188	847
INS-PROP,LIAB,WC	0	28	39	25	24	33	150
DEPRECIATION	0	140	194	125	119	165	744
RENT	0	360	499	322	306	424	1,911
MAINTENANCE	0	35	49	31	30	41	186
FEES & PUBLIC	0	0	0	0	0	0	0
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$0	$6,866	$9,507	$6,132	$5,830	$8,077	$36,411
FIXED ASSETS							
EQUIP - PRIOR	0	7,800	10,800	6,966	6,623	9,176	41,365
EQUIP - CURR	0	3,770	5,220	3,367	3,201	4,435	19,992
EQUIP - FULLY DEP	0	3,600	4,985	3,215	3,057	4,235	19,092
BLDG - PRIOR	0	1,268	1,756	1,132	1,077	1,492	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
DECEMBER 2003

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	20.59%	25.92%	16.26%	15.70%	21.52%	100.00%
SALARIES-ADMIN	$0	$2,967	$3,735	$2,344	$2,263	$3,102	$14,410
SALARIES-CLERIC	0	1,985	2,499	1,568	1,514	2,075	9,641
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	297	374	234	226	310	1,442
ACCOUNTING	0	(34)	(42)	(26)	(26)	(35)	(163)
WORK COMP INS	0	3	4	2	2	3	14
SUPPLIES	0	69	87	55	53	72	336
TELEPHONE	0	102	128	81	78	107	496
EMPL BENEFITS	0	888	1,118	702	677	928	4,313
PAYROLL TAXES	0	270	340	213	206	282	1,311
TRAVEL	0	70	88	55	53	73	340
IN SERVICE	0	69	87	54	52	72	334
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	0	20	26	16	16	21	99
OWNERS COMP	0	174	220	138	133	182	847
INS-PROP,LIAB,WC	0	31	39	24	24	32	150
DEPRECIATION	0	153	193	121	117	160	744
RENT	0	393	495	311	300	411	1,911
MAINTENANCE	0	38	48	30	29	40	186
FEES & PUBLIC	0	0	0	0	0	0	0
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$0	$7,497	$9,438	$5,922	$5,717	$7,837	$36,411
FIXED ASSETS							
EQUIP - PRIOR	0	8,517	10,722	6,727	6,495	8,903	41,365
EQUIP - CURR	0	4,116	5,182	3,251	3,139	4,303	19,992
EQUIP - FULLY DEP	0	3,931	4,949	3,105	2,998	4,109	19,092
BLDG - PRIOR	0	1,385	1,743	1,094	1,056	1,447	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
JANUARY 2004

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	20.88%	26.10%	17.10%	14.63%	21.30%	100.00%
SALARIES-ADMIN	$0	$2,906	$3,632	$2,380	$2,036	$2,965	$13,919
SALARIES-CLERIC	0	2,011	2,513	1,646	1,409	2,051	$9,630
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	515	643	421	360	525	$2,464
ACCOUNTING	0	12	15	10	9	12	$58
WORK COMP INS	0	17	21	14	12	18	$82
SUPPLIES	0	109	136	89	76	111	$520
TELEPHONE	0	111	139	91	78	113	$532
EMPL BENEFITS	0	853	1,066	698	597	870	$4,083
PAYROLL TAXES	0	395	493	323	276	403	$1,890
TRAVEL	0	56	69	45	39	57	$266
IN SERVICE	0	119	148	97	83	121	$568
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	0	55	69	45	38	56	$263
OWNERS COMP	0	172	215	141	121	176	$825
INS-PROP,LIAB,WC	0	30	38	25	21	31	$145
DEPRECIATION	0	152	190	124	106	155	$728
RENT	0	378	473	310	265	386	$1,812
MAINTENANCE	0	9	12	8	7	10	$45
FEES & PUBLIC	0	6	7	5	4	6	$28
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$0	$7,905	$9,879	$6,472	$5,537	$8,065	$37,859
FIXED ASSETS							
EQUIP - PRIOR	0	12,812	16,011	10,489	8,974	13,070	61,357
EQUIP - CURR	0	0	0	0	0	0	0
EQUIP - FULLY DEP	0	3,987	4,982	3,264	2,793	4,067	19,092
BLDG - PRIOR	0	1,404	1,755	1,150	984	1,433	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
FEBRUARY 2004

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	20.75%	26.61%	17.37%	14.35%	20.92%	100.00%
SALARIES-ADMIN	$0	$2,888	$3,705	$2,418	$1,997	$2,911	$13,919
SALARIES-CLERIC	0	1,998	2,563	1,673	1,382	2,014	$9,630
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	511	656	428	354	515	$2,464
ACCOUNTING	0	12	15	10	8	12	$58
WORK COMP INS	0	17	22	14	12	17	$82
SUPPLIES	0	108	138	90	75	109	$520
TELEPHONE	0	110	142	92	76	111	$532
EMPL BENEFITS	0	847	1,087	709	586	854	$4,083
PAYROLL TAXES	0	392	503	328	271	395	$1,890
TRAVEL	0	55	71	46	38	56	$266
IN SERVICE	0	118	151	99	81	119	$568
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	0	55	70	46	38	55	$263
OWNERS COMP	0	171	220	143	118	173	$825
INS-PROP,LIAB,WC	0	30	38	25	21	30	$145
DEPRECIATION	0	151	194	126	104	152	$728
RENT	0	376	482	315	260	379	$1,812
MAINTENANCE	0	9	12	8	6	9	$45
FEES & PUBLIC	0	6	8	5	4	6	$28
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$0	$7,856	$10,076	$6,577	$5,432	$7,918	$37,859
FIXED ASSETS							
EQUIP - PRIOR	0	12,732	16,330	10,659	8,803	12,833	61,357
EQUIP - CURR	0	0	0	0	0	0	0
EQUIP - FULLY DEP	0	3,962	5,081	3,317	2,739	3,993	19,092
BLDG - PRIOR	0	1,395	1,790	1,168	965	1,407	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
MARCH 2004

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	19.39%	26.42%	17.65%	14.65%	21.88%	100.00%
SALARIES-ADMIN	$0	$2,700	$3,678	$2,457	$2,039	$3,046	$13,919
SALARIES-CLERIC	0	1,868	2,545	1,700	1,411	2,107	$9,630
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	478	651	435	361	539	$2,464
ACCOUNTING	0	11	15	10	9	13	$58
WORK COMP INS	0	16	22	15	12	18	$82
SUPPLIES	0	101	137	92	76	114	$520
TELEPHONE	0	103	141	94	78	116	$532
EMPL BENEFITS	0	792	1,079	721	598	893	$4,083
PAYROLL TAXES	0	367	499	334	277	413	$1,890
TRAVEL	0	52	70	47	39	58	$266
IN SERVICE	0	110	150	100	83	124	$568
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	0	51	70	46	39	58	$263
OWNERS COMP	0	160	218	146	121	181	$825
INS-PROP,LIAB,WC	0	28	38	26	21	32	$145
DEPRECIATION	0	141	192	129	107	159	$728
RENT	0	351	479	320	265	396	$1,812
MAINTENANCE	0	9	12	8	7	10	$45
FEES & PUBLIC	0	6	8	5	4	6	$28
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$0	$7,343	$10,004	$6,683	$5,546	$8,284	$37,859
FIXED ASSETS							
EQUIP - PRIOR	0	11,900	16,213	10,831	8,988	13,425	61,357
EQUIP - CURR	0	0	0	0	0	0	0
EQUIP - FULLY DEP	0	3,703	5,045	3,370	2,797	4,177	19,092
BLDG - PRIOR	0	1,304	1,777	1,187	985	1,471	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
APRIL 2004

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	18.90%	25.39%	17.16%	15.58%	22.98%	100.00%
SALARIES-ADMIN	$0	$2,630	$3,533	$2,388	$2,169	$3,199	$13,919
SALARIES-CLERIC	0	1,820	2,445	1,652	1,501	2,213	$9,630
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	466	626	423	384	566	$2,464
ACCOUNTING	0	11	15	10	9	13	$58
WORK COMP INS	0	16	21	14	13	19	$82
SUPPLIES	0	98	132	89	81	120	$520
TELEPHONE	0	100	135	91	83	122	$532
EMPL BENEFITS	0	772	1,037	701	636	938	$4,083
PAYROLL TAXES	0	357	480	324	294	434	$1,890
TRAVEL	0	50	67	46	41	61	$266
IN SERVICE	0	107	144	97	88	130	$568
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	0	50	67	45	41	60	$263
OWNERS COMP	0	156	209	142	129	190	$825
INS-PROP,LIAB,WC	0	27	37	25	23	33	$145
DEPRECIATION	0	138	185	125	113	167	$728
RENT	0	342	460	311	282	416	$1,812
MAINTENANCE	0	9	11	8	7	10	$45
FEES & PUBLIC	0	5	7	5	4	7	$28
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$0	$7,154	$9,611	$6,495	$5,900	$8,700	$37,859
FIXED ASSETS							
EQUIP - PRIOR	0	11,594	15,576	10,527	9,561	14,099	61,357
EQUIP - CURR	0	0	0	0	0	0	0
EQUIP - FULLY DEP	0	3,608	4,847	3,275	2,975	4,387	19,092
BLDG - PRIOR	0	1,271	1,707	1,154	1,048	1,545	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
MAY 2004

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	19.11%	24.58%	17.31%	16.54%	22.45%	100.00%
SALARIES-ADMIN	$0	$2,660	$3,422	$2,410	$2,303	$3,125	$13,919
SALARIES-CLERIC	0	1,841	2,367	1,667	1,593	2,162	$9,630
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	471	606	427	408	553	$2,464
ACCOUNTING	0	11	14	10	10	13	$58
WORK COMP INS	0	16	20	14	14	18	$82
SUPPLIES	0	99	128	90	86	117	$520
TELEPHONE	0	102	131	92	88	119	$532
EMPL BENEFITS	0	780	1,004	707	676	917	$4,083
PAYROLL TAXES	0	361	465	327	313	424	$1,890
TRAVEL	0	51	65	46	44	60	$266
IN SERVICE	0	108	140	98	94	127	$568
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	0	50	65	46	44	59	$263
OWNERS COMP	0	158	203	143	136	185	$825
INS-PROP,LIAB,WC	0	28	36	25	24	32	$145
DEPRECIATION	0	139	179	126	120	163	$728
RENT	0	346	445	314	300	407	$1,812
MAINTENANCE	0	9	11	8	7	10	$45
FEES & PUBLIC	0	5	7	5	5	6	$28
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$0	$7,236	$9,306	$6,555	$6,263	$8,499	$37,859
FIXED ASSETS							
EQUIP - PRIOR	0	11,727	15,082	10,623	10,151	13,775	61,357
EQUIP - CURR	0	0	0	0	0	0	0
EQUIP - FULLY DEP	0	3,649	4,693	3,305	3,159	4,286	19,092
BLDG - PRIOR	0	1,285	1,653	1,164	1,113	1,510	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
JUNE 2004

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	19.54%	24.18%	17.81%	16.37%	22.10%	100.00%
SALARIES-ADMIN	$0	$2,720	$3,366	$2,479	$2,279	$3,075	$13,919
SALARIES-CLERIC	0	1,882	2,329	1,715	1,577	2,128	9,630
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	482	596	439	403	544	2,464
ACCOUNTING	0	11	14	10	10	13	58
WORK COMP INS	0	16	20	15	13	18	82
SUPPLIES	0	102	126	93	85	115	520
TELEPHONE	0	104	129	95	87	118	532
EMPL BENEFITS	0	798	987	727	668	902	4,083
PAYROLL TAXES	0	369	457	337	309	418	1,890
TRAVEL	0	52	64	47	44	59	266
IN SERVICE	0	111	137	101	93	125	568
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	0	51	64	47	43	58	263
OWNERS COMP	0	161	199	147	135	182	825
INS-PROP,LIAB,WC	0	28	35	26	24	32	145
DEPRECIATION	0	142	176	130	119	161	728
RENT	0	354	438	323	297	400	1,812
MAINTENANCE	0	9	11	8	7	10	45
FEES & PUBLIC	0	6	7	5	5	6	28
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$0	$7,400	$9,154	$6,743	$6,198	$8,365	$37,859
FIXED ASSETS							
EQUIP - PRIOR	0	11,992	14,836	10,927	10,044	13,557	61,357
EQUIP - CURR	0	0	0	0	0	0	0
EQUIP - FULLY DEP	0	3,732	4,616	3,400	3,125	4,218	19,092
BLDG - PRIOR	0	1,314	1,626	1,198	1,101	1,486	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
JULY 2004

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	19.21%	24.89%	17.15%	16.52%	22.23%	100.00%
SALARIES-ADMIN	$0	$2,674	$3,465	$2,387	$2,299	$3,094	$13,919
SALARIES-CLERIC	0	1,850	2,397	1,652	1,591	2,141	9,630
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	473	613	423	407	548	2,464
ACCOUNTING	0	11	14	10	10	13	58
WORK COMP INS	0	16	20	14	14	18	82
SUPPLIES	0	100	130	89	86	116	520
TELEPHONE	0	102	132	91	88	118	532
EMPL BENEFITS	0	785	1,016	700	674	908	4,083
PAYROLL TAXES	0	363	470	324	312	420	1,890
TRAVEL	0	51	66	46	44	59	266
IN SERVICE	0	109	141	97	94	126	568
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	0	51	66	45	43	58	263
OWNERS COMP	0	159	205	141	136	183	825
INS-PROP,LIAB,WC	0	28	36	25	24	32	145
DEPRECIATION	0	140	181	125	120	162	728
RENT	0	348	451	311	299	403	1,812
MAINTENANCE	0	9	11	8	7	10	45
FEES & PUBLIC	0	5	7	5	5	6	28
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$0	$7,274	$9,424	$6,493	$6,253	$8,415	$37,859
FIXED ASSETS							
EQUIP - PRIOR	0	8,109	10,506	7,239	6,971	9,381	42,207
EQUIP - CURR	0	2,294	2,972	2,047	1,972	2,653	11,938
EQUIP - FULLY DEP	0	3,668	4,753	3,274	3,153	4,244	19,092
BLDG - PRIOR	0	1,292	1,674	1,153	1,111	1,495	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0